Virginia Rural Health Care Plan

Virginia's Application for Participation in the Medicare Rural Hospital Flexibility Program

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Executive Summary
Virginia Rural Health Care Plan

Under the direction of the Center for Primary Care and Rural Health, in the Virginia Department of Health (VDH), a rural health plan was commissioned in June of 1999. Researchers at the Rural Health Policy Program at Virginia Tech, Blacksburg, Virginia, drafted the plan between June, 1999 and April of 2000. Early in the process, an advisory committee, the Critical Access Taskforce (CAT), was named to oversee the completion of the plan and to provide direction in setting the goals and administrative processes for the Medicare Rural Hospital Flexibility Program. The State Health Commissioner reviewed the Virginia Rural Health Care Plan prior to submission to the Health Care Financing Administration (HCFA).

Six goals were established to guide Virginia in integrating Critical Access Hospitals into its rural health systems. As specified by the advisory committee the six goals are as follows.

Goal I: Ensure access to hospitals and other health services for residents in rural Virginia.

Goal II: Facilitate the number and quality of rural health networks on a local and regional basis**.**
Goal III: Create an efficient administrative infrastructure to guide and to oversee the state's Critical Access Hospital program.
Goal IV: Educate and assist rural hospitals desiring to convert to Critical Access Hospitals to ensure their sustainability and to promote quality of care.
Goal V: Ensure a regulatory framework supportive of the creation of Critical Access Hospitals.
Goal VI: Educate the Virginia General Assembly and members of the Virginia Hospital and Healthcare Association about the Medicare Rural Hospital Flexibility Program and Critical Access Hospital designation in order to help them make informed policy choices.

Administrative processes and program directives are being established to ensure that progress towards achieving the goals is achieved in a thoughtful and expeditious manner.

An important part of the Virginia Rural Health Care Plan is the identification of eligible hospitals. In the Plan, criteria for designation of "necessary provider" hospitals are established. Legislative authorization for implementing the necessary provider criteria was also obtained. Necessary provider hospitals increase the pool of hospitals within the state eligible for "Critical Access Hospital" designation beyond those established by the federal government in the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999. Sixteen hospitals were identified as possible candidates for CAH status in the immediate future. Three of the sixteen hospitals filed letters of inquiry during the planning process.

The Plan details administrative processes and protocols for application for CAH status, for educational and technical assistance programs for hospitals interested in pursuing CAH status, and for monitoring and evaluating Critical Access Hospitals as well as the progress towards the goals of the Plan.

The VDH Center for Primary Care and Rural Health is the lead agency for the state Medicare Rural Hospital Flexibility Program (MRHFP). A Critical Access Taskforce (CAT) has been created consisting of the following members to advise the Center on a continuing basis:

1. A representative from the Virginia Rural Health Association.
2. Representatives from the Center for Primary Health Care and Rural Health, Virginia Department of Health.
3. The State Health Commissioner.
4. A representative of the Virginia Hospital and Healthcare Association.
5. A representative from the Center for Quality Health Care Services and Consumer Protection, Virginia Department of Health, which is responsible for licensure and certification of hospitals.
6. At least one and no more than three rural hospital administrators.

7. Other representatives as deemed necessary by the State Health Commissioner.

The Virginia Rural Health Care Plan provides a blueprint for improving health care access in rural communities within the Commonwealth, while assuring that quality of health care is maintained. The Critical Access Hospital program will enable a number of rural hospitals experiencing financial difficulties to remain as providers of quality care to their communities.

Introduction

Purpose of the Virginia Rural Health Care Plan

In the Balanced Budget Amendment of 1997 (BBA), Congress established the Medicare Rural Hospital Flexibility Program (MRHFP) for state participation. The 1997 BBA as amended in the Balanced Budget Refinement Act of 1999 enables states to establish Critical Access Hospitals (CAHs) as a category for Medicare cost-based reimbursement. Rural hospitals designated as CAHs will be reimbursed on a cost basis rather than the current Diagnostic Related Group (DRG) system of fixed reimbursement. To participate in the MRHFP, states must submit a rural health care plan that specifies the goals and objectives of the state's Rural Hospital Flexibility Program; the criteria the state adopts to designate Critical Access Hospitals; and the administrative structures and processes established to implement, administer, and monitor the program. This document represents the Virginia Rural Health Care Plan for the Commonwealth of Virginia and is submitted pursuant to participation in the Medicare Rural Hospital Flexibility Program established by the US Congress.

Preparation of the Virginia Rural Health Care Plan

The Center for Primary Care and Rural Health, Virginia Department of Health (VDH) has responsibility for the preparation and administration of the Virginia Rural Health Care Plan. Preparation of the Plan was delegated to the Rural Health Policy Program at Virginia Polytechnic Institute and State University in Blacksburg, Virginia.

An advisory committee consisting of the following members assisted in the preparation of the Virginia Rural Health Care Plan:

1 Representative from the Virginia Rural Health Association.
2 Representatives from the Center for Primary Care and Rural Health.
3 Representative of the Virginia Hospital and Healthcare Association.
4 Representative from the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection, which is the VDH department responsible for certification and licensing of hospitals.
5 Rural Hospital administrators.
6 Representative of the Medical Society of Virginia.

The advisory committee provided direction in developing the Plan goals and reviewed the entire Plan prior to submission to HCFA.

Profile of Virginia's Rural Areas

Fifty-four percent or 73 of Virginia's 135 counties and independent cities are nonmetropolitan[1]. Metropolitan counties in the Commonwealth are concentrated in the urban corridor that extends from the Washington D.C. metropolitan region to the Tidewater urban conurbation of Virginia Beach, Norfolk,

[1] Virginia is the only state that legally recognizes "independent cities". From the census perspective independent cities are enumerated in the same manner as counties. Although labeled "cities", some of Virginia's independent cities are actually classified as nonmetropolitan. For purposes of this document, the term county is inclusive of the independent city category.

Chesapeake, and Hampton. Nonmetropolitan[2] counties are distributed throughout the state but distinct regional groupings exist (Figure 1).

Regional Variations in Rural Virginia

The nonmetropolitan counties in Southwestern Virginia are mountainous and historically have relied on extraction industries (coal and forestry). Rural "Southside" Virginia in the Appalachian Piedmont is one of the poorer regions of the state economically. The decline in agricultural production, particularly in tobacco, and the lost jobs in the textile industry have left many local economies with high unemployment. Counties in the northwestern region of the state are mountainous and rely primarily on forest products and tourism for their economic livelihood. These counties that adjoin rural counties in the Shenandoah Valley are prosperous agriculturally and have benefited from economic growth associated with the I-81 corridor of the state. In the central portion of the state nonmetropolitan counties span both the mountainous region of the Blue Ridge and the rolling terrain of the Piedmont. Expansion of metropolitan regions such as Richmond and Fredericksburg has slowly been changing the character of the counties from rural to suburban. Finally, along the extreme east coast, including the Delmarva Peninsula, lie a series of counties that has maintained its rural character despite the metropolitan expansion within the urban corridor.

The geographic distinctions between Virginia's nonmetropolitan counties are important because each region has different demographic and social characteristics, health care needs, and health care resources. Any rural health plan for the Commonwealth must recognize and respect these regional differences if effective networks of care are to be developed and maintained.

[2] Nonmetropolitan is used here in the manner used by the U.S. Census, i.e., not metropolitan. Although the census distinguishes between rural and nonmetropolitan (former being not urban and the latter not metropolitan), for purposes of this report rural and nonmetropolitan are used interchangeably. Where the term rural is used it is assumed to mean nonmetropolitan unless defined otherwise.

Regional Planning Infrastructure

The regional planning in the Commonwealth is organized through 21 regional planning districts (PD) (Figure 2). Each PD has a commission (PDC) responsible for policies and oversight of regional planning activities within the region. Professional staff are responsible for developing and implementing programs and projects that are regional in scope and impact. Although the planning districts have no direct administrative ties to the Virginia Department of Health or other state health organizations, the districts can be used to help local organizations, hospitals for example, build coalitions, provide data required for community assessments, and help organize forums for engaging citizens in local planning efforts.

For purposes of the Virginia Rural Health Care Plan, the PDs have been grouped into four rural regions generally corresponding to the historic divisions of the state noted earlier (Figure 3). Throughout the report, these four regions are used as a means to illustrate important differences in socio-demographic, social, economic, and health conditions between nonmetropolitan counties within the state.

Socio-Demographic Attributes

Nonmetropolitan county growth rates for the eight-year period from 1990 to 1998 averaged nearly 8% lower than those for metropolitan counties (Table 1). Nearly 30% of the nonmetropolitan counties in the state lost population in the nineties, as compared to less than 20% of the metropolitan counties.

The divergent growth rates for metropolitan and nonmetropolitan jurisdictions are projected to continue through the next five years. Past and projected differentials in population growth between metropolitan

and nonmetropolitan regions are an important reality of the state's nonmetropolitan counties. The demographic trends both reflect and shape the current economic, social and health care realities of rural communities.

Regional differences in rural population dynamics are evident. Rural counties in the Southwestern region have a long history of population losses that is largely attributable to the decline in coal production in the region. Rural counties in the region continue to grow at lower rates than counties in other regions of the state. Fourteen of the 21 counties in that area of the state lost population between 1990 and 1998.

Table 1

Population Dynamics 1990 to 1998 by County And Nonmetropolitan Regions

	Average Percent Change in Population: 1990-1998	Number of Counties with Population Loss: 1990 -1998	Counties with Population Loss: 1990 –1998 %	Estimated Population Change 1998-2004 In Percents
Metropolitan	+12.22%	11	17.0%	+11.5%
Nonmetropolitan	+4.93%	21	28.7%	+8.89%
Nonmetropolitan Regions[1]				
Northwest	+6.55%	4	20.0%	+9.48%
Southwest	+1.00%	14	51.9%	+6.30%
Middle-South	+8.67%	2	14.2%	+11.7%
Eastern	+6.69%	1	8.3%	+9.68%

[1]See figure three for regional boundaries

Source: U.S. Bureau of Census, *Population Estimates for Virginia, 1999* and, Virginia Hospital and Healthcare Association, *Healthy Communities in Virginia, 1999*, Richmond, March 2000.

Population growth in the region is minimal, only a 1.0% increase over the eight-year period, and the projected growth is well below rural counties in other areas of the state. Nonmetropolitan counties in the other three regions had higher growth rates although none approached the increases evident in metropolitan counties. The higher rates of growth in the middle-south portion of the state reflect the proximity of metropolitan centers to rural counties here. County rates clearly illustrate the continued concentration of growth in the eastern urban corridor in the state and the consequent population impacts on adjacent rural counties (Figure 4).

In addition to demographic variability, rural regions in the state exhibit important social and economic differentials. The differentials mean that programs and processes suitable to one region may be inappropriate for others. Models for health system integration will undoubtedly fail if they are not sensitive to regional social and economic contexts.

An important distinction in racial composition exists between the two western regions (northwestern and southwestern) and those in the eastern sector of the state. In middle-south and eastern nonmetropolitan counties African-Americans constitute over one third of the population (Table 2). These figures contrast sharply with the lower percentages (<11%) to the west.

Older adults (65 and older) constitute a high percentage of the population in all nonmetropolitan counties (Table 2). Moreover, the elderly percentages have been increasing slowly but steadily over the past two decades. The increases reflect a historic pattern of out-migration of younger adults to metropolitan centers both in Virginia or other states. In contrast, middle-aged and older residents have chosen to remain, creating an aging-in-place process that further skews the age distribution. Since the elderly are large

consumers of health care services, the demand for health services increases despite overall population growth that is modest or negative in some counties.

Rural counties in the Commonwealth generally have benefited from the sustained economic prosperity of the 1990s. Most counties are experiencing historic low unemployment rates, albeit higher than in urban areas. However, the benefits of economic growth are not uniformly distributed within the state's local economies (Table 2). The southwestern and eastern regions of the state lag behind in economic growth. In both instances, the current figures reflect persistent lower employment patterns related to declines in agricultural production, particularly tobacco, reductions in extraction industries such as coal and timber production, and the movement of textile and clothing manufacturing firms offshore or to other states. Because of

Table 2

Social Attributes of Nonmetropolitan Counties: 1998

	Social/ Demographic Attributes		Economic Attributes			Educational Attributes
	% Pop. Black	% Pop. 65 plus	% Unemp	% Below Poverty Level	Median HH Income	% [1] Without HS Degree
Metropolitan	21.4 %	12.5%	2.8%	10.9%	$39,870	26.5%
Nonmetropolitan	21.6 %	15.9%	4.8%	15.6%	$28,501	39.9%
Nonmetropolitan Regions						
Northwest	10.9 %	15.2%	3.0%	12.1%	$20,597	34.8%
Southwest	7.2%	15.5%	6.1%	16.5%	$17,876	41.4%
Middle-South	47.9 %	15.4%	4.7%	18.7%	$17,057	45.3%
Eastern	39.9 %	18.8%	5.2%	16.4%	$21,002	38.4%

[1]Percentages are for the population 25 years and older.

[2] ACH refers to national achievement scores.
[3]Figures are only for nonmetropolitan counties in the regions.
Source: Virginia Hospital and Healthcare Association, *Healthy Communities in Virginia, 1999*, Richmond, March 2000.

the poorer economic base in these counties, public support in the form of tax revenues for health services is low. Also, the loss of jobs in the clothing, textile, and coal industries in the past twenty years has resulted in the loss of affordable health insurance for many.

Unfortunately, the educational levels of the employment pool are a constraint on future economic development in all of the nonmetropolitan counties. In the southwest and middle-south regions, for example, the proportion of the population 25 and older without a high school degree approaches 50% (Table 2).

Demographic, social and economic indicators for Virginia's rural counties paint a familiar cycle of poverty and decline. Population out-migration has created an older population that demands more health services and is withdrawn from the labor force. Low and decreasing tax bases resulting from the loss of economic enterprises lead to less investment in human capital. Poor educational performance creates a labor force unable to compete in today's global, technology-driven economy, which precipitates more out-migration of the better-educated youth. Within this context, health services must be funded, accessible and of high quality.

Health Status

Given the historic patterns of depopulation, employment losses, and lower investments in human capital, it is not surprising that the health status of residents in Virginia's rural counties is generally below that of

their metropolitan counterparts. It is true that within some central cities health outcomes are also poor. However, indicators such as low birth weight babies, overall mortality rates, age/sex adjusted mortality rates for health disease and infant deaths paint a profile of health that is common in rural communities that are struggling economically and socially (Table 3).

The status of health in rural counties varies regionally generally in association with the social and economic patterns observed above. Although patterns vary according to the particular indicator, the general trend is for lower health status in the rural counties in the middle-south and eastern regions (Table 3). Counties in the east, for example, have the highest overall and infant mortality rates.

Table 3

Health Status Measures in Nonmetropolitan Counties: 1998

	Low Birth Weight Baby as % of Total 1991-95 Average	Mortality Rate per 1,000	Infant Deaths Per 1,000 Births	Heart Disease[1] Deaths Per 100,000	Lung/Bronchus Cancer Deaths Per 100,000
Metropolitan	7.38	8.9	6.9	135.5	42.6
Nonmetropolitan	7.96	12.1	8.2	152.2	41.8
Nonmetropolitan Regions					
Northwest	7.03	10.7	8.5	142.8	39.6
Southwest	7.28	11.8	7.2	156.7	37.9
Middle-South	10.02	12.8	8.1	160.4	46.6
Eastern	8.69	13.9	10.7	139.2	49.3

[1]Rates for deaths by heart disease and by lung/bronchus cancer have been standardized by age and gender.
Virginia Hospital and Healthcare Association, *Healthy Communities in Virginia, 1999*, Richmond, March 2000.
Data on low birth weights were from the Virginia Department of Health.

Although health status is influenced by social, behavioral, and environmental factors in rural counties, when access to health services is limited by cost or geographic constraints, health status suffers. From a financial perspective, access to health services is generally lower in nonmetropolitan than in metropolitan

counties, although the differences are not as great as one might anticipate given current economic conditions. The uninsured percentages, for example, are comparable (Table 4). The similarities in rates of the uninsured reflect in part the higher proportions of rural residents on some form of public insurance. On a proportional basis, Medicaid enrollment, for example, is significantly higher in rural counties (Table 4).

Enrollment in the State Children's Health Insurance Program (SCHIP) in Virginia suggests that the problem in accessing health services is not solely a function of lack of insurance resources. Even though nonmetropolitan counties are doing better than their metropolitan counterparts in enrollment in the program, over 44% of children eligible for the health services under SCHIP have not enrolled. Educational and promotional campaigns have not drawn the projected number of eligible children into the program as anticipated.

Table 4
Access to Health Services in Nonmetropolitan Counties

	% Uninsured	% Enrolled in Medicaid
Metropolitan	13.5%	7.0%
Nonmetropolitan	14.0%	11.1%
Nonmetropolitan Regions		
Northwest	14%	7.3%
Southwest	14.9%	12.3%
Middle-South	14.0%	13.1%
Eastern	12.0%	11.9%

Source: Virginia Hospital and Healthcare Association, *Healthy Communities in Virginia, 1999*, Richmond, March 2000.

Components of an Integrated Rural Health System

A fundamental goal of the state's Medicare Rural Hospital Flexibility Program is the formation and maintenance of integrated rural health systems. In Virginia some integration of health systems has

occurred through the efforts of individual hospital systems. Some hospitals have begun to integrate their networks of clinics and physicians' practices. Since these efforts have been initiated by individual organizations, not all elements necessary for an integrated system may exist because benefits must exceed costs for longer-term maintenance. Services that are not good profit centers will not be well integrated into the system. Emergency medical services, for example, have not always been a focus of many of these system expansion efforts for these reasons. The integration of systems has proceeded more rapidly in urban or suburban counties than in rural counties. Some hospital systems do reach out to nonmetropolitan communities but significant gaps in system development in rural counties are evident.

Primary Care Components

Primary care services are well developed in some rural counties in the state, but in the majority of counties the primary care systems are not fully developed. Of the state's nonmetropolitan counties, 73% are defined as medically underserved by federal standards (Figure 5) and 34% carry a HPSA (Health Professional Shortage Area) designation (Figure 6).

To address these manpower shortages and to meet the medical needs of uninsured residents in rural communities, 51 Community Health Centers have been established around the state. The majority (70%) are Federally Qualified Health Centers (FQHC). All of the clinics, FQHCs or not, are associated with the Virginia Primary Care Association. All of the centers provide core primary care services designed to meet the needs of residents in their jurisdictions who are unable to obtain care through more traditional means. The services include but are not limited to:

- Physician care
- Preventive services (mammography, well-child, immunizations, etc.)
- Diagnostic services (x-rays, laboratory work, etc.)
- Case management

- Referral services

The Community Health Centers are located primarily (70%) in rural counties. They are distributed throughout the state's rural communities, but the largest numbers are in the southwestern, middle-south, and in eastern counties surrounding the Chesapeake Bay (Figure 7).

In some rural communities an important primary care component for the uninsured is Free Clinics. Of Virginia's 32 free clinics, 15 are found in rural counties (Figure 7). Free Clinics provide medical services to individuals with no health insurance and some clinics provide pharmaceuticals to Medicare patients with chronic illnesses. Volunteer medical professionals staff Free Clinics. Some clinics have salaried nurse practitioners on staff who are supported by three-year grants from the Virginia Health Care Foundation. Clinics rely heavily on local hospitals and other health institutions for diagnostic work and on the benevolence of medical specialists for referrals. The reliance on specialty physicians and medical institutions for support limits the effectiveness of Free Clinics in those rural communities that do not have those resources to draw upon.

Virginia also has approximately 70 HCFA certified Rural Health Clinics. These clinics have had a significant impact on increasing the primary care coverage in many of the same areas in which potential CAHs exist. The fact that each Rural Health Clinic must have a midlevel provider on staff has also assisted in the diffusion of nurse practitioners and physician assistants into Virginia's rural communities.

Primary care services are networked with hospitals and emergency services in a limited number of rural counties in the state. Where networks exist, they are associated with hospital systems that have developed primary care clinics and integrated them into the hospitals' catchment areas. In cases where hospital

systems' networks extend across contiguous counties, such as the Carilion system, or for academic health centers, such as the University of Virginia Medical Center, rural primary care networks may be widely distributed geographically. The number of existing networks is limited, however, and in most rural counties, primary care networks are fragmented and greater coordination is required. Physicians and clinics attempt to coordinate activities, but it is not always done in a systematic fashion so gaps either in geographic coverage or for particular services occur. An aim of Virginia's MRHFP is to ensure coordination and integration so that the geographic coverage is more extensive and that all residents are able to obtain care as needed.

Rural Hospitals as a System Component

In 1999 Virginia had 97 acute care hospitals[3]. Thirty-six of those hospitals are located in nonmetropolitan counties (Figure 8). Thirty-eight counties are without a hospital but every nonmetropolitan county without a hospital has one situated in an adjacent county. Still, for nearly 20% of rural counties, residents are at least twenty miles from the nearest hospital (Figure 9)[4]. If the county is in the mountainous region of the state, even twenty-miles may constitute at least a forty-minute drive.

Hospitals in nonmetropolitan Virginia exhibit many of the attributes found in rural hospitals in other states. The hospitals generally have significantly fewer beds, have lower occupancy levels on the average, shorter lengths of stay, and small staffs compared to those in metropolitan regions (Table 5). The ratio of licensed to staffed beds is also high because management must adjust their bed capacity to accommodate the reduction in demand for in-patient services that has been occurring.

[3] Carilion's Memorial and Community Hospitals are included as one Medical Center for purposes of this study. The state also has 26 outpatient surgical centers or hospitals. All of the surgical centers are in urban centers.
[4] Miles were calculated from a county centroid to the nearest hospital.

Important differences exist in rural hospital attributes within the state (Table 5). Hospitals in the northwestern section generally are larger in size than in the other regions. Smaller hospitals, in terms of both bed size and employment, are prevalent in the more mountainous southwestern region. Here too, average length of stay is the shortest and the licensed/staffed bed ratio the highest. Rural hospitals in the eastern region of the state are also smaller on average than rural hospitals in general but unlike institutions in the southwest, occupancy rates in the eastern region are higher than those encountered in other nonmetropolitan and in metropolitan counties.

Table 5

Average Attributes of Virginia's Hospitals
1997-1998

	Number of Staffed Beds per Hospital	Occupancy Rate for Staffed Beds	Ratio of Licensed Beds to Staffed Beds	Average Length of Stay	Full-Time Employee Equivalent
Metropolitan	212.7	63.4	1.46	7.3	1,088
Nonmetropolitan	85.6	60.6	1.67	4.2	437
Nonmetropolitan Regions					
Northwest	145	56.7	1.51	4.5	732
Southwest	67.4	60.2	1.77	3.9	349
Middle-South	95.2	63.7	1.42	4.6	459
Eastern	67.5	67.8	1.69	4.6	358
State-Wide	161.9	62.3	1.54	6.06	828

Source: Annual data from the Virginia Health Information organization.

The financial health of rural hospitals in Virginia has historically been good, although this has not always been the result of a given hospital's operating margin. Other sources of revenue have enabled some hospitals to remain solvent. Despite this general trend one rural hospital, Wise Appalachian Regional Hospital, has closed during the past three years. Moreover, the financial health of rural hospitals has

deteriorated significantly in recent years for a variety of reasons, most notably among them the Medicare cuts resulting from the Balanced Budget Act of 1997. Rural hospitals also face growing numbers of uninsured patients, low Medicaid reimbursement (Virginia Medicaid reimburses hospitals at approximately 72% of costs), and rising costs of prescription drugs and nursing staff. All of these forces are increasing the financial pressures on rural hospitals throughout the state.

The net balance between revenues and allowable costs for rural hospitals is low in general and in the southwest and eastern counties the average figures indicates a number of hospitals are approaching a critical situation (Table 6). In the 1997-1998 fiscal period, in seven rural hospitals the costs exceed revenues. Of those seven, five are located in the southwestern region. Preliminary data suggest that the situation will be still worse in 1999.

The financial stress confronting rural hospitals is exacerbated by rural communities' demographics. The higher levels of poverty and lower household incomes evident in rural communities, particularly in the eastern and southwestern regions, often result in the need for rural hospitals to provide uncompensated care (Table 6). This is particularly true in the eastern and southwestern regions. In these two areas uncompensated care, as a percentage of patient revenues is about 75% of the state average.

Increased dependence on outpatient care as a source of patient revenues is another important attribute of the state's rural hospitals. In 25% of rural hospitals, inpatient services account for less than half of patient revenues (Table 6). The reduced reliance on in-patient care does give hospitals some flexibility to downsize even further their bed capacity. This could enable smaller hospitals to meet the bed requirement for a Critical Access Hospital without jeopardizing in-patient revenues.

Table 6

Financial Attributes of Rural Hospitals
1997

	Revenues less Costs per 100 Discharges	Uncompensated Care Dollars per $1,000 Gross Patient Revenues	In-Patient Gross Revenues as Percent of Gross Revenues
Metropolitan	$1110.76	$23.17	63.4%
Nonmetropolitan	$585.70	$18.20	55.1%
Nonmetropolitan Regions			
Northwest	$928.41	$23.67	53.4
Southwest	$484.23	$15.81	54.1
Middle-South	$714.96	$24.00	62.5
Eastern	$389.53	$16.05	55.2
State-Wide	$900.74	$21.2	60.1%

Source: Virginia Health Information, 1999.

Emergency Medical Services as a System Component

The Commonwealth of Virginia has emphasized the development of local emergency medical services to ensure that rural communities have good access to medical care in times of greatest need. Thirty-two of the 36 rural hospitals have emergency rooms. To support the emergency room facilities, emergency medical services in rural counties have been upgraded and expanded in the past ten years. Although the number of EMS organizations within metropolitan counties exceeds those for nonmetropolitan counties, the number of EMS personnel and emergency vehicles is higher in rural counties on a per capita basis (Table 7). Within the state's rural counties EMS services do vary (Table 7). Rural counties in the northwest have the more well developed and staffed emergency medical services, while those counties in the eastern and southern portions of the state have the least developed. As Figure 10 illustrates, the relationship between the presence of a rural hospital and the density of EMS services is not well developed as yet. A number of rural counties with hospitals have lower basic life support `personnel ratios,

particularly in the southwestern portion of the state. The absence of a denser EMS network in association with some rural hospitals indicates an area where future efforts of the Medicare Rural Hospital Flexibility Program must be directed.

Table 7

Emergency Medical Services in Rural Virginia

	Average Number of Emergency Medical Organizations in a County	Average[1] Basic Life Support Personnel Per 1,000 population	Average[2] Emergency Vehicles per 1,000 Population	Average Percent of Emergency Medical Units Classified as Volunteer
Metropolitan	6.6	2.76	.56	.47
Nonmetropolitan	5.0	3.49	.92	.73
Emergency Medical Services in Nonmetropolitan Regions				
Northwest	6.6	5.03	1.04	.79
Southwest	5.0	2.84	.88	.72
Middle-South	3.8	2.98	.99	.55
Eastern	3.7	2.97	.75	.86
State-Wide Average	5.7	3.15	.76	.61

[1]Basic Life Support Personnel are defined as First Responders and Emergency Medical Technicians.
[2] The 1998 populations for the counties are used for the calculations. Emergency medical data is for 1999.
Source: Office of Emergency Medical Services, Department of Health, Commonwealth of Virginia.

Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program for the Commonwealth of Virginia reflects federal requirements for the program and the unique aspects and needs of the state's rural communities. Although federal requirements must be met in implementing the program, federal guidelines enable states to adapt their program to the particular circumstances of their rural conditions.

The principal element of the Medicare Rural Hospital Flexibility Program is the establishment of a new, permanent hospital payment classification called "Critical Access Hospitals" (CAHs). Critical Access Hospitals will be reimbursed from Medicare on a cost basis instead of the current DRG-based system. CAH designations are intended to help small rural hospitals remain financially viable in communities that are unable or may be unable to support their existing hospital under current market conditions.

The Medicare Rural Hospital Flexibility program as specified in the Balanced Budget Act of 1997 and as amended in the subsequent Balanced Budget Refinement Act of 1999 stipulates that certain requirements be met before a hospital can be designated as "Critical Access Hospital" and eligible for cost-based reimbursement. Foremost among those requirements is that a state must have adopted a federally approved state rural health care plan that articulates goals for the state's Medicare Rural Hospital Flexibility Program. The state's plan is required to be developed in consultation with the hospital association of the state, rural hospitals located in the state, and the state office of rural health.[5] The plan must:

1. Provide for the creation of one or more rural health networks.
   These networks should include:
   a. At least one Critical Access Hospital that is affiliated with a secondary hospital.
   b. An integrated emergency medical component of the network.
   c. Coordination of health services within the region.
2. Promote the regionalization of rural health services.
3. Improve access to hospital and other health services in rural areas.

Goals for the Virginia Rural Health Care Plan

The advisory committee responsible for the formulation of the Virginia Rural Health Care Plan established six goals to guide the future of Virginia's Medicare Rural Hospital Flexibility Program.

[5] See Appendix IV for the participants in the development of the Virginia rural health plan.

1. Ensure access to hospitals and other health services for residents in rural Virginia.
2. Facilitate the development and maintenance of rural health networks on a local and regional basis.
3. Create an efficient administrative infrastructure to guide and to oversee the state's Critical Access Hospital program.
4. Educate and assist rural hospitals wishing to convert to Critical Access Hospital status to ensure their sustainability and to promote quality of care.
5. Ensure a regulatory framework supportive of the creation of Critical Access Hospitals.
6. Educate the Virginia General Assembly and members of the Virginia Hospital and Healthcare Association about the Medicare Rural Hospital Flexibility Program and Critical Access Hospital designation in order to help them make informed policy choices.

Goal I: Insure access to hospitals and other health services for residents in rural Virginia.

The Critical Access Taskforce (see subsequent section on administration) will assume responsibility for reviewing progress in accessibility to health services, particularly in hospitals that are designated as Critical Access Hospitals. The Taskforce will periodically review data from the state on rural access for the purpose of developing recommendations for future programs. As structured, the Taskforce gives the State Health Commissioner a broad, representative group of health professionals that can be used as a resource for developing and reviewing new initiatives in rural health.

Goal II: Increase the number and quality of rural health networks on a local and regional basis.

Under the leadership of the Critical Access Taskforce (CAT), current technical, legal, financial, workforce, and regulatory issues associated with integrating health services locally and regionally will be assessed. A report that documents current barriers and opportunities for network development will be produced and distributed to both state health officials and members of the health community within the state.

As part of the process of reviewing existing network maintenance and format, VDH will determine the best practices for the establishment of effective rural networks. This will be done using Virginia case studies as well as data from other states that have created effective networks of care within their rural areas. The best

practices study will help hospital leaders and other health care providers expand upon existing network arrangements and facilitate the new networks within the state.

Within the next two years the state, working with the Technical Assistance and Services Center for the Rural Hospital Flexibility Program (TASC), VDH will create at least one rural network that includes a Critical Access Hospital. A number of potential CAHs have been identified (see later section on CAH designation), and representatives from three rural hospitals have participated in developing this Plan and have expressed strong interest in obtaining CAH designation (Appendix III).

Goal III: Facilitate an efficient administrative infrastructure to guide and to oversee the state's Critical Access Hospital program.

Administrative authority for the Rural Flexibility program will be under the aegis of the State Health Commissioner of the Commonwealth of Virginia. The Commissioner has responsibility for the Center for Primary Care and Rural Health, which is the office that will assume principal responsibility for ensuring that the Virginia Rural Health Care Plan is implemented successfully. The Commissioner also has direct administrative authority over the Center for Quality Health Care Services and Consumer Protection, which currently is responsible for licensure and certification issues pertaining to hospitals and health care facilities within the Commonwealth.

To provide policy assistance to the State Health Commissioner on the Medicare Rural Hospital Flexibility Program, a Critical Access Taskforce (CAT) has been formed that consists of the following members:

1. A representative from the Virginia Rural Health Association.
2. Representatives from the Center for Primary Health Care and Rural Health, Virginia Department of Health.
3. A representative from the Medical Society of Virginia.
4. A representative of the Virginia Hospital and Healthcare Association.

5. A representative from the Center for Quality Health Care Services and Consumer Protection, Virginia Department of Health, which is responsible for licensure and certification of hospitals.
6. Three Rural Hospital administrators.
7. Other representatives as deemed necessary by the State Health Commissioner.

The Critical Access Taskforce will review information called for in the Virginia Rural Health Care Plan and make recommendations to the State Health Commissioner on rural health network developments, rural access issues, the status of Critical Access Hospitals, and progress achieved towards fulfilling the Virginia Rural Health Care Plan on a biannual basis.

Goal IV: **Educate and assist rural hospitals wishing to convert to Critical Access Hospitals to ensure their sustainability and to promote quality of care.**

Four objectives have been established for the creation of Critical Access Hospitals. All four objectives are to be achieved by December 2000.

1. Develop eligibility criteria for Critical Access Hospitals that reflect both federal and state needs.
2. Develop an educational program in conjunction with the Virginia Hospital and Healthcare Association to inform hospitals of the eligibility criteria for Critical Access Hospital status as well as the advantages and disadvantages of that status.
3. Identify the consulting services (financial analysis, quality improvement, community assessment tools, and workforce planning) required to assist hospitals in making decisions regarding CAH status and to aid them in their transition.
4. Establish the procedures and protocols for CAH application, implementation, and monitoring.

Detailed discussion of the four objectives is provided in the subsequent section of the Plan entitled "Designation of Critical Access Hospitals**."**

Goal V: Insure a regulatory framework supportive of the creation of Critical Access Hospitals.

Because Virginia has Certificate of Public Need requirements, legal and regulatory issues pertaining to Critical Access Hospitals were anticipated. To ensure that no state regulatory barriers could forestall

participation in the Medicare Rural Hospital Flexibility Program, Senate Bill 665 was introduced in the 2000 session of the Virginia General Assembly. The legislation resulted after review of state's statutes pertaining to hospital licensure, regulation and financing indicated that changes were needed in state laws. As approved by the General Assembly the legislation removes any foreseeable constraints on implementation of CAHs within the Commonwealth and gives the Health Department the necessary authority to implement and oversee the program (See Appendix II for the language of the bill).

Goal VI: Educate the Virginia General Assembly and members of the Virginia Hospital and Healthcare Association about the Medicare Rural Hospital Flexibility Program and Critical Access Hospital designation in order to help them make informed policy choices.

To keep important stakeholders knowledgeable about the goals of the Medicare Rural Hospital Flexibility Program and the policies and procedures adopted for implementation of Critical Access Hospitals, the Critical Access Taskforce will coordinate regular presentations to the Virginia Hospital and Healthcare Association and the Joint Commission on Health Care. In addition, a Web Page will be established to provide information on the program goals and objectives, responses to common questions, and relevant changes in federal policies that pertain to program goals and requirements.

Criteria for Designation of Critical Access Hospitals

Federal Criteria for Critical Access Hospital Designation

An important element of the Medicare Rural Hospital Flexibility Program is the establishment of criteria for designating Critical Access Hospitals. Although the federal legislation provides discretion for states' designation of CAHs, the minimum federal requirements for CAHs must be met before approval is granted. The federal requirements for CAHS are set forth in the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 respectively. Public, non-profit, or private[6] hospitals are eligible for CAH status if they meet the following requirements.

[6] Eligibility of private hospitals was established in the 1999 Balanced Budget Act. The Act also permits for-profit hospitals and hospitals that have closed or downsized to health centers or clinics in the past 10 years to be CAHs.

Location Criteria

1. The hospital is located 35 miles from the nearest hospital,
2. The hospital is located 15 miles from the nearest hospital in a mountainous area, or
3. The hospital is designated a "necessary provider" by the state.

Network Criteria

1. The Critical Access Hospital must have a formal agreement with a secondary hospital designating the CAH as a member of the secondary hospital's network.
2. The CAH must have an agreement concerning credentialing and quality assurance programs with one network hospital and with the PRO or equivalent entity as identified in the State rural health plan.
3. The CAH must have agreements with at least one network hospital addressing:
   a) Patient referral and transfer
   b) The development and use of communications systems including:
      i. Telemetry systems
      ii. Systems for electronic sharing of patient data
   c) The provision of emergency and non-emergency transportation between the CAH and the network hospital.

Size and Operations Criteria

1. The CAH may not have more than 15 acute inpatient beds
   a. The hospital may have up to 25 beds including skilled nursing beds but not more than 15 beds can be used for acute care at any one time.
2. Average inpatient stays should be no longer than 96 hours
   a. Some exceptions are permitted under specific conditions, for example, if inclement weather or emergency conditions preclude transfer.
   b. Monitoring of the length of stay criteria is based on an annual average for the facility.
3. The CAH must have 24-hour emergency medical services
   a. Staffing requirements for emergency services need not meet those for full hospital status, but a physician must be available on call if the emergency warrants.

Staff Requirements

The CAH must meet the staffing requirements that would apply under section 1861(e) of the Social Security Act to a hospital located in a rural area, except that:

a) The facility need not meet hospital standards relating to the number of hours during a day or week which the facility must be open and fully staffed except for the 24-hour emergency care requirements. Otherwise the facility need only be staffed when an inpatient is present.

b) The facility may provide any services otherwise required to be provided by a full-time or part-time staff, or make arrangements for such services.
c) A nurse practitioner, physicians assistant, or clinical nurse specialist subject to the oversight of a physician may provide the inpatient care.

2. A mid-level practitioner (NP, PA, or Clinical Nurse Specialist) may provide care under the remote supervision of a physician if allowed by the Virginia Board of Medicine and the Virginia Board of Nursing.

Virginia Necessary Provider Criteria

Based on the analysis of Virginia's rural hospitals, the Critical Access Taskforce, established the following criteria for a hospital to be designated as a "necessary provider", and thus, eligible for Critical Access Hospital designation. To be classified as a necessary provider a hospital must be the sole provider in a county[7] and meet two of the following five conditions:

1. The hospital is located in a nonmetropolitan county that is a federally designated Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA)
2. The hospital is located in a county where the percentage of poverty exceeds the state percentage as specified in the most recent U.S. census of population.
3. The percentage of the hospital's revenue from Medicare must exceed the state average for Medicare reimbursement.
4. The hospital is located in a county where the percentage of population 65 and older is greater than the state average as specified in the most recent estimate of population and age.
5. The Hospital is located in a county whose most recent three-year unemployment rate average exceeds the same three-year average rate for the state.

Potential Critical Access Hospitals in Virginia

Based on the federal criteria and the necessary provider designation adopted for the Virginia Rural Health Care Plan, an assessment of all rural hospitals was done to determine the number of potential CAHs in the

[7] Because Virginia's independent cities are treated as counties in the census and share many of the jurisdictional rights of counties, the sole provider criteria needs to be adjusted. Many nonmetropolitan independent cities are very small in size and in geographic extent. All are completely surrounded by a county and in may instances, the hospitals that serve the county are located in the independent city. Consequently, for the necessary provider criteria, independent city hospitals are counted as being associated with the surrounding county. Operationally this means that for independent cities a sole provider hospital is one that is the only hospital in the independent city and its surrounding county.

state. The identification of potential hospitals was based on application of the federal location criteria[8] and an analysis of current operations. Potential hospitals are those that meet the requirements and currently have staffed bed size of 40 or fewer beds (Table 8). Under the appropriate conditions, it was believed, based on discussions with hospital administrations, that hospitals with less than 40 staffed beds would be able and willing to scale their bed size to the required numbers to met CAH designation.

A total of five hospitals are likely candidates for CAH status. All of these hospitals qualify by the federal distance criteria. Another eleven hospitals meet federal or necessary provider criteria but their bed size and average daily census figures suggest that they are unlikely to seek CAH status.

As the average daily census figures in Table 8 illustrate, a number of hospitals are operationally below or near an average daily census of 15, suggesting that downsizing to 15 acute beds would be feasible. Although five hospitals are potential candidates, certainly not all will be willing to make the conversion necessary for CAH status. Three letters of inquiry, however, have been received from hospitals on the list indicating that Critical Access Hospital program will benefit some rural hospitals in the Commonwealth (Appendix III).

Table 8

Potential CAH Hospitals

Hospital Name	Location[1] (County)	Meet Federal Distance Criteria	Meet Virginia Necessary Provider	Staffed Beds	Average Daily Census

[8]Distances were calculated using ArcView GIS and are based on straight-line distances from the hospital to the nearest hospital. In the mountainous terrain, the distance estimates represent conservative figures. Driving distances and times would be much greater because of the terrain.

Bath County Community Hospital	**Bath County**	✔		12	7.5
Carilion Giles Memorial Hospital	**Giles County**	✔		32	14.6
Dickenson County Medical Center	**Dickenson County**	✔		39	20.1
Page Memorial Hospital	**Page County**	✔		20	16.3
Patrick Community Hospital	**Patrick County**	✔		34	11.7

[1]All of the counties listed are considered mountainous. All of these counties are located totally or partially in the Blue Ridge Mountain system, Alleghany Highlands, or the Appalachian Ranges.

Medicare Rural Hospital Flexibility Program – Administrative Structures and Processes

The State Health Commissioner will have administrative responsibility for the Medicare Rural Hospital Flexibility Program and for the application and review process for Critical Access Hospital status. The VDH Center for Primary Care and Rural Health will provide the staffing and technical support necessary to implement the program and the VDH, Center for Quality Health Care Services and Consumer Protection will monitor compliance.

Application Process

Inquiries from hospitals seeking Critical Access Hospital status will be submitted to the Center for Primary Care and Rural Health. Upon receipt of an inquiry the Center will provide the hospital with the requirements and specifications that must be addressed in a formal application. These include the following.

1) A financial analysis of the implications of conversion to CAH status
2) A community needs assessment.
3) Documentation of public participation by all significant stakeholders in the decision.

4) A formal agreement between the petitioning hospital and the secondary hospital. The agreement must include:
    a) Statement acknowledging that the secondary hospital will agree to all transfers from the petitioning hospital
    b) Statement acknowledging that the petitioning hospital will be included in the quality review process of the secondary hospital
5) The CAH must have an agreement concerning credentialing and quality assurance programs with one network hospital and with Virginia's Peer Review Organization, the Virginia Health Quality Center or an equivalent entity.
6) The CAH must have agreements with at least one network hospital addressing:
    a) Patient referral and transfer
    b) The development and use of communications systems
        i) Telemetry systems
        ii) Electronic sharing of patient data
    c) The provision of emergency and non-emergency transportation among the facility and the hospital.
7) A statement of assurance and a plan demonstrating that the hospital will meet the bed need and length of stay requirements of CAH status.
8) A statement of assurance and a plan demonstrating that the petitioning hospital will meet the emergency medical care are requirements of Critical Access Hospitals.

VDH will also provide to the applicant a list of consultants capable of providing financial analyses, community needs assessments, and other technical assistance required by hospitals to assess the feasibility of converting to a Critical Access Hospital. Hospitals may choose consultants other than those on the list, but the VDH list will represent those qualified for CAH assessment based on experience and capabilities[9]. Grants from the Center for Primary Care and Rural Health will be available to hospitals for consulting assistance.

Formal applications will be submitted to the Center for Primary Care and Rural Health. Upon receipt of the application, staff in the Center for Primary Care and Rural Health and the Center for Quality Health Care Services and Consumer Protection will review it and verify that the application meets the requirements specified in the Virginia Rural Health Care Plan and that no conflicts exist with state regulations or licensure requirements.

Applications submitted for consideration must include the following materials:

1. Application form.
2. Documentation indicating an agreement with a network hospital and other health care providers pertaining to referral and transfer of patients, credentialing and quality review, and provision of emergency and non-emergency transportation.
3. Analysis of the financial feasibility of CAH status for the petitioning hospital.
4. Documentation of meetings with relevant stakeholders.
5. A community needs assessment.
6. Assurance of compliance with bed size and length-of-stay requirements.
7. Assurance of compliance with emergency medical availability.

After review and approval by VDH, the application will be submitted to Medicare for review and approval.

Education and Technical Assistance

To ensure that the hospital administrators are fully informed of the requirements for Critical Access Hospital status, the application process, and the implications of CAH status, the Virginia Hospital and Healthcare Association (VHHA) in consultation with VDH will develop an educational plan associated with CAHs. The VHHA has scheduled information sessions on Critical Access Hospitals at their fall meeting on November 8, 2000. The Association will also use its print media to announce the program, will provide information on application requirements, will produce educational materials on the positive and negative aspects of Critical Access Hospital conversion, and will hold workshops as needed.

The VHHA has developed a set of Healthy Community Indicators that will be useful for community needs assessments and program monitoring. In cooperation with the Rural Health Policy Program at Virginia Tech those indicators are available on a Web site (http://www.rhpp.vt.edu). The Web site may be

[9] A procedure will be established for consultants to be placed on the "recommended" list.

expanded to include information – questions and answers, changes in policy, and other relevant news – on the Medicare Rural Hospital Flexibility Program and Critical Access Hospitals.

To help hospital personnel make informed decisions on conversion to CAH status, VDH will compile a list of consultants. The VHHA and VDH will publicize the consultant list. To be eligible for inclusion on the list, consultants must demonstrate experience and expertise in the financial analysis methodologies required to make sound fiscal judgments about conversion, in community needs assessment, in community participation methodologies, or in legal or regulatory issues relevant to conversion.

Once a hospital has identified appropriate consulting expertise, grants to hospitals will be available from the Center for Primary Care and Rural Health to support the consulting. To be eligible for an assistance grant, a hospital must have filed a letter of inquiry.

Monitoring and Evaluation

Administrative responsibility for monitoring and evaluating Critical Access Hospital compliance will rest with the Center for Primary Care and Rural Health and the Center for Quality Health Care Services and Consumer Protection within VDH. Staff in those offices will develop the requirements for monitoring and evaluation. The requirements will focus on two aspects of the program:

1. Compliance with state and federal regulations concerning CAHs on the following
    a. Bed size
    b. Average Length of Stay
    c. Network Affiliation
    d. Emergency Medical System
    e. Staffing Requirements
    f. Network Development
2. Quality Assurance
    a. Licensing and certification requirements

b. Credentialing and quality review agreements with network hospital
c. State quality assurance requirements

The timetable for evaluation will be published and distributed prior to Certification of any CAHs.

Conclusion

The Virginia Rural Health Care Plan provides a blueprint for assisting hospitals that wish to become Critical Access Hospitals with the overarching goal of improving health care access in rural communities within the Commonwealth, while assuring that quality of care is maintained. The Critical Access Hospital program will enable a number of rural hospitals experiencing financial difficulties to remain as providers of quality care to their communities.

An important part of the Plan is the identification of eligible hospitals that are most likely to apply for Critical Access Hospital status. In this Plan, criteria for designation of “necessary provider” hospitals are established. Legislative authorization for implementing the necessary provider criteria was also obtained in Senate Bill 665 (Appendix II). The "necessary provider" designation defined in the plan will increase the pool of hospitals within the Commonwealth eligible for CAH designation and help to preserve institutions upon which communities depend for many services in addition to health care. Five hospitals were identified as potentially eligible for CAH status in the immediate future. Three of the five hospitals filed letters of inquiry during the planning process.

The Virginia Rural Health Care Plan details administrative processes and protocols for application for CAH status, describes educational and technical assistance programs for hospitals interested in pursuing CAH status, and enumerates the monitoring and evaluating process for Critical Access Hospitals.

Appendix I

Figures for the Virginia Rural Health Care Plan

Appendix II

Senate Bill 665 of the Virginia General Assembly

VIRGINIA ACTS OF ASSEMBLY -- CHAPTER

An Act to amend and reenact § 32.1-122.07 of the Code of Virginia, relating to rural health.

[S 665]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-122.07 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-122.07. Authority of Commissioner for certain health planning activities.

A. The Commissioner, with the approval of the Board, is authorized to make application for federal funding and to receive and expend such funds in accordance with state and federal regulations.

B. The Commissioner shall administer section 1122 of the United States Social Security Act if the Commonwealth has made an agreement with the United States Secretary of Health and Human Services pursuant to such section.

C. In compliance with the provisions of the Balanced Budget Act of 1997, P.L. 105-33, and any amendments to such provisions, the Commissioner shall submit to the appropriate regional administrator of the Health Care Financing Administration (HFCA) an application to establish a Medicare Rural Hospital Flexibility Program in Virginia.

D. The Commissioner shall develop and the Board of Health shall approve a rural health care plan for the Commonwealth to be included with the application to establish a Medicare Rural Hospital Flexibility Program. In cooperation and consultation with the Virginia Hospital and Health Care Association, the Medical Society of Virginia, representatives of rural hospitals, and experts within the Department of Health on rural health programs, the plan shall be developed and revised as necessary or as required by the provisions of the Balanced Budget Act of 1997, P.L. 105-33, and any amendments to such provisions. In the development of the plan, the Commissioner may also seek the assistance of the Planning Board and the regional health planning agencies. The plan shall verify that the Commonwealth is in the process of designating facilities located in Virginia as critical access hospitals, shall note that the Commonwealth wishes to certify facilities as "necessary providers" of health care in rural areas, and shall describe the process, methodology, and eligibility criteria to be used for such designations or certifications. Virginia's rural health care plan shall reflect local needs and resources and shall, at minimum, include, but need not be limited to, a mechanism for creating one or more rural health networks, ways to encourage rural health service regionalization, and initiatives to improve access to health services, including hospital services, for rural Virginians.

E. Notwithstanding any provisions of this chapter or the Board's regulations to the contrary, the Commissioner shall, in the rural health care plan, (i) use as minimum standards for critical access hospitals, the certification regulations for critical access hospitals promulgated by the Health Care Financing Administration pursuant to Title XVIII of the Social Security Act, as amended; and (ii) authorize critical access hospitals to utilize a maximum of ten beds among their inpatient hospital beds as swing beds for the furnishing of services of the type which, if furnished by a nursing home or certified nursing facility, would constitute skilled care services without complying with nursing home licensure

requirements or retaining the services of a licensed nursing home administrator. Such hospital shall include, within its plan of care, assurances for the overall well-being of patients occupying such beds.

F. Nothing herein or set forth in Virginia's rural health care plan shall prohibit any hospital designated as a critical access hospital from leasing the unused portion of its facilities to other health care organizations or reorganizing its corporate structure to facilitate the continuation of the nursing home beds that were licensed to such hospital prior to the designation as a critical access hospital. The health care services delivered by such other health care organizations shall not be construed as part of the critical access hospital's services or license to operate.

3. That the application required by subsection C of § 32.1-122.07 shall be submitted no later than June 1, 2000, and a draft of the plan required by subsection D of § 32.1-122.07 shall be completed prior to June 1, 2000, and shall be submitted with such application. The Board of Health shall approve the first such plan, as required by subsection D of § 32.1-122.07, by August 1, 2000.

Appendix III

Letters of Inquiry from Hospitals